



# Health Savings Account Enrollment Form Dodge County

Plan Year	No. of Pay Periods

## Employee Information (Please Print Legibly)

Employee's Name		Date of Birth	Social Security Number
Home Address:			
Home Phone		Email Address (we do not share your email address)	
I am enrolling in a Health Savings Account:			I am changing my employee contribution:
Effective Date (must be a Pay Date):			Effective Date (must be a Pay Date):

## OPTION 1: Employee Benefits Corporation (EBC)

☐ I elect to enroll in the Health Savings Account through Employee Benefits Corporation (EBC):

High Deductible Health Plan: ☐ Single ☐ Family

By affixing my signature below, I certify that the information provided on this form and any attachments, including my Social Security Number is correct, true and complete. I am covered, or will be as of the effective start date, by a qualified High Deductible Health Plan. I also certify I am not covered by any other health coverage that is incompatible with an H.S.A (including, but not limited to Medicare, TriCare, or a Health FSA), and I am not claimed by anyone else (other than a spouse) as a dependent for tax purposes. I am not subject to backup withholding because: a. I am exempt from backup withholdings or b. I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or c. the IRS has notified me that I am no longer subject to backup withholding. I understand that in the event of a mistaken contribution as defined in IRS Notice 2008-59, Sections 23-25 my employer may need to request that prior deposited funds withdrawn from my Health Savings Account in order to correct the error. I have reviewed and agree to the following Agreements and Disclosures that have been provided to me for my Health Savings Account: Custodial Agreement; Deposit Account Agreement; Truth in Savings Disclosure, Find Availability Disclosure Agreement; External Funds Transfer Agreement; and the Privacy Statement. I consent to electronic delivery of account statements and understand I can change delivery preferences once enrolled for online access. I appoint Avidia Bank as custodian of my Health Savings Account. I understand that I can revoke this authorization of appointment within seven (7) days from the date of opening by H.S.A. by mailing a written notice to Avidia Bank, PO Box 370, Hudson, MA 01749. I understand that if I separate from employment but choose to retain my H.S.A. through Employee Benefits Cooperation, I will be Subject to a \$2.50 monthly maintenance fee. I am a US Citizen or other US person as defined by the IRS.

## OR

## OPTION 2: Employee's Own Financial Institution Information

☐ I wish to use my own Financial Institution to set up my Health Savings Account:

High Deductible Health Plan: ☐ Single ☐ Family

Financial Institution \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Account Number \_\_\_\_\_ Routing Number (exactly 9 digits) \_\_\_\_\_

## Additional Election Amounts

Yearly Max. Employer+Employee: \$3500 Single \$7000 Family Age 55+ additional \$1000	Employee Contribution (per pay period)	Employee Contribution (# of pay periods)	Total Employee Contribution Per Calendar Year
Pre-Tax H.S.A. Contributions			
Post-Tax Contributions			

Note: Post tax deductions should only be entered above if an individual is ineligible to make a pre-tax contribution to an H.S.A. (for example, a partner in a partnership or more than 2% share holder of an S corporation)

By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the Qualifying event. I agree to hold my employer harmless from any liability to my participation in this plan.

## Signature and Acknowledgement

Employee Signature	Date
--------------------	------